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IN THE
Supreme Court of the United States
OCTOBER TERM, 1980

MARK MILLS ET AL.,
Petitioners,
v.
RUBIE ROGERS ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

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BRIEF FOR THE AMERICAN PSYCHOLOGICAL ASSOCIATION, AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, AND MENTAL HEALTH ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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OTHER AUTHORITIES:

Ananth & Beszterczey, *Treatment of Psychosis Subsequent to Phenothiazine-induced Agranulocytosis*, 14 Compr. Psych. 319 (1973) 5
Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Am. J. Psych. 340 (1980) 27
Ayd, *Cardiovascular Effects of Phenothiazines*, 5 Int'l Drug Therapy Newsletter 1 (1970) 5
Ayd, *A Survey of Drug-Induced Extrapyramidal Reactions*, 175 J.A.M.A. 1054 (1961) 4
Baldessarini, R., CHEMOTHERAPY IN PSYCHIATRY (1977) 8

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Baldessarini & Lipinski, *Risks vs. Benefits of Antipsychotic Drugs*, 289 New Eng. J. Med. 427 (1973) 5, 6, 8

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Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 Bull Am. Acad. Psych. & L. 179 (1980) 4, 7, 27

Crane, *Clinical Psychopharmacology in Its 20th Year*, 181 Sci. 124 (1973) 4, 25

Crane, *Two Decades of Psychopharmacology and Community Mental Health: Old and New Problems of the Schizophrenic Patient*, in 36 TRANSACTIONS OF THE N.Y. ACAD. OF SCIENCES, ser. II (1974) 7

Crane, *The Prevention of Tardive Dyskinesia*, 134 Am. J. Psych. 756 (1977) 6

Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190 (1974) 15, 16, 18

Dubose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?*, 60 Minn. L. Rev. 1149 (1976) 5

Eisenberg, *Psychiatric Intervention*, 229 Scientific Am. 116 (1973) 8

Estroff, S. MAKING IT CRAZY: AN ETHNOGRAPHY OF PSYCHIATRIC CLIENTS IN AN AMERICAN COMMUNITY (1981) 4, 7

Goldstone *et al.*, *Effects of Trifluoperazine, Chlorpromazine, and Haloperidol Upon Temporal Information Processing by Schizophrenic Patients*, 64 Psychopharmacology 119 (1979) 7

Gunderson, *Drugs and Psychosocial Treatment of Schizophrenia Revisited*, 38 J. Cont. Educ. Psych. 25 (1977) 8

TABLE OF CASES AND AUTHORITIES—Continued

Page

Hammond, K., & Joyce, C., PSYCHOACTIVE DRUGS AND SOCIAL JUDGMENT: THEORY AND RESEARCH (1975) 7

Helmchen, *Schizophrenia: Diagnostic Concepts in the ICD-8*, in STUDIES OF SCHIZOPHRENIA (M. Lader ed. 1975) 18

Hershon, Kennedy & McGuire, *Persistence of Extra-pyramidal Disorders and Psychiatric Relapse after Withdrawal of Long-Term Phenothiazine Therapy*, 120 Brit. J. Psych. 41 (1972).. 9

Joint Info. Serv. of Am. Psych. Ass'n & Nat'l Ass'n for Mental Health, *Psychiatric Points of View Regarding Laws and Procedures Governing Medical Treatment of the Mentally Ill* (Special Info. Bull. No. 1, Sept. 1962) 18

Karon & VandenBos, *The Consequences of Psychotherapy for Schizophrenic Patients*, 9 Psychotherapy: Theory, Research & Prac. 111 (1972).. 8

Karon, B., & VandenBos, G., PSYCHOTHERAPY OF SCHIZOPHRENIA: THE TREATMENT OF CHRONIC MENTAL PATIENTS (1977) 8, 9

Kennedy, Hershon & McGuire, *Extrapyramidal Disorders After Prolonged Phenothiazine Therapy*, 118 Brit. J. Psych. 509 (1971) 4

Klawans *et al.*, *Neuroleptic-Induced Tardive Dyskinesias in Nonpsychotic Patients*, 30 Arch. Neurology 338 (1974) 6

Klawans, *The Pharmacology of Tardive Dyskinesia*, 130 Am. J. Psych. 82 (1973) 6

Lorr, M., Klett, C., & McNair, D., SYNDROMES OF PSYCHOSIS (1963) 18

MODERN SYNOPSIS OF COMPREHENSIVE TEXTBOOK OF PSYCHIATRY/II (A. Freedman, H. Kaplan & B. Sadock eds. 1976) 5

Moore & Book, *Sudden Death in Phenothiazine Therapy*, 44 Psych. Q. 389 (1970) 5

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Ozarin, Redick & Taube, *A Quarter Century of Psychiatric Care, 1950-1974: A Statistical Review*, 27 Hosp. & Comm. Psych. 515 (1976) 26
Paul, G., & Lentz, R., PSYCHOSOCIAL TREATMENT OF CHRONIC MENTAL PATIENTS (1977) 8, 9
PHYSICIANS DESK REFERENCE (33d ed. 1979) 6
Ray, O., DRUGS, SOCIETY AND HUMAN BEHAVIOR (1978) 26
Shader, Appleton & DiMascio, *Ophthalmological (Pigmentary) Changes*, in PSYCHOTROPIC DRUG SIDE EFFECTS (R. Shader & A. DiMascio eds. 1970) 5
Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 So. Cal. L. Rev. 237 (1974) 13
Sovner *et al.*, *Tardive Dyskinesia and Informed Consent*, 19 Psychosomatics 172 (1978) 6, 7
Stone, *Informed Consent: Special Problems for Psychiatry*, 30 Hosp. & Comm. Psych. 321 (1979) 17
Stone, *The Right to Refuse Treatment*, 38 Arch. Gen. Psych. 358 (1981) 17, 18
Tardive Dyskinesia, Task Force Report of the American Psychiatric Association (1978) 4, 6, 8
Taube, Regier & Rosenfeld, *Mental Disorders*, in U.S. Dept. of Health, Education & Welfare, HEALTH, UNITED STATES 69 (1978) 26
Tepper & Haas, *Prevalence of Tardive Dyskinesia*, 24 J. Clin. Psych. 508 (1979) 6
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Van Putten, *Subjective Response as a Predictor of Outcome in Pharmacotherapy*, 35 Arch. Gen. Psych. 477 (1978) 18

Van Putten, *Why Do Schizophrenic Patients Refuse to Take Their Drugs?*, 31 Arch. Gen. Psych. 67 (1974) 8

Yang & Guillan, *Sudden Death Syndrome*, J. Kan. Med. Soc. 547 (1979) 5

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INTEREST OF *AMICI CURIAE*

Amici curiae are two organizations of mental health professionals and one citizens' organization, many of whose members have direct experience working in state hospitals for the mentally ill.[1] The members of these

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[1] The American Psychological Association is a voluntary nonprofit scientific and professional organization, founded in 1892, of approximately 50,000 psychologists, many of whom work in public institutions.

The American Orthopsychiatric Association is an interdisciplinary organization of over 8,000 members including psychiatrists, psychologists, social workers, psychiatric nurses, educators, and

organizations—psychiatrists, psychologists, social workers, and psychiatric nurses—are charged with day-to-day responsibility for providing treatment to residents of state mental institutions, and are familiar with both the problems of institutionalized patients and the use and misuse of antipsychotic drugs in institutional settings.

Amici have received consent to file this brief from both petitioners and respondents. Their letters of consent are being filed with the Clerk of this Court.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case requires the Court to decide whether, absent an emergency, a competent civilly committed individual has a constitutional right to decide whether to submit to the forced administration of antipsychotic drugs.

In Part I, *amici* demonstrate that antipsychotic drugs are an extremely intrusive form of treatment with dangerous, sometimes irreversible side effects. They further demonstrate that alternative forms of treatment, which may be more effective, are available.

In Part II, *amici* set forth the appropriate balancing analysis, weighing the competing individual and state interests presented by this case. Petitioners and *amicus* American Psychiatric Association contend that involuntary commitment is a sufficient justification for forcibly medicating an individual with antipsychotic drugs. They do not show, however, that this result appropriately takes into account the competing interests of competent individuals to make their own treatment decisions, particularly when Massachusetts law holds that the decision to civilly commit is not equivalent to a determination of incompetency.

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allied professionals, concerned with the problems, causes and treatment of abnormal behavior.

The Mental Health Association is an organization of one million lay and professional members whose primary purpose is to encourage efforts to provide better services for the mentally ill.

Although involuntary civil commitment necessarily results in a substantial infringement of certain protected liberty interests, committed individuals still retain significant interests in bodily integrity, free thought, and self-determination which must be considered in determining whether the state may force objecting individuals to undergo a particular form of "treatment." Those interests must be weighed against the various interests asserted by the state, which include a paternalistc interest in treating objecting individuals "for their own good," a public health interest in treating objecting individuals for the good of society, and administrative interests in the secure and efficient operation of mental institutions. As will be shown, absent an emergency, there are no state interests sufficient to outweigh the fundamental liberty interests of a competent civilly committed person in being free to decide whether to submit to the administration of antipsychotic drugs.

I. ANTIPSYCHOTIC DRUGS CAUSE SERIOUS, SOMETIMES PERMANENT SIDE EFFECTS AND MAY NOT BE MORE EFFECTIVE THAN ALTERNATIVE FORMS OF TREATMENT.

Antipsychotic drugs[2] alter electro-chemical transmissions in the brain and cause dramatic changes in the patient's body, mind, and mood. Although the initial

[2] Three groups of drugs are principally used to treat patients with mental disorders: (1) sedative agents, (2) antidepressants, and (3) antipsychotic agents. The first group is normally prescribed for neurotic disorders; the second group for depressive disorders; and the third group for psychotic disorders, especially schizophrenia. The most common antipsychotics are Thorazine (chlorpromazine), Stelazine (trifluoperazine), Trilafon (perphenazine), Mellaril (thioridazine), Prolixin (fluphenazine), Navane (thiothexene), and Haldol (haloperidol). Although the term antipsychotic may misleadingly suggest a high degree of effectiveness against psychosis, *amici* will use this term—rather than the more neutral and preferable synonyms "psychotropic" or "psychoactive" —to conform with the lower courts' choice of nomenclature.

physical invasion is minimal—a simple injection or pill—"the impact of the chemicals upon the brain is sufficient to undermine the foundations of personality." *In re Guardianship of Richard Roe, III*, No. SJC-2257, slip op. at 29 (Mass. Sup. Jud. Ct. April 23, 1981). As one commentator has stated, "[a] total catalogue of the side effects caused by antipsychotic medications . . . would be a horrendous document . . . ranging from dry mouth to death." Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 Bull. Am. Acad. Psych. & L. 179, 184 (1980); see *Tardive Dyskinesia, Task Force Report of the American Psychiatric Association* (1978) [hereinafter cited as *APA Task Force Report*].

A. Physical Side Effects

The most obvious side effects of antipsychotic drugs are physical, and the most common of these generally are referred to as extrapyramidal symptoms. As the district court found below, these extrapyramidal effects include: muscle spasms, irregular flexing, writhing or grimacing movements, and protrusion of the tongue (dystonic reactions); motor restlessness, and inability to stay still (akathesia); and mask-like face, drooping, stiffness and rigidity, shuffling gait, and tremors (pseudo-parkinsonian syndrome). 478 F. Supp. at 1360; Pet. App. at 2a.[3] In lay language, persons on antipsychotic drugs may develop "the shakes, stiffness, blank expression, [shuffling] gait, leg jiggling, eye rolling and facial grimacing." Brooks, *supra*, at 184 (citing S. Estroff, MAKING IT CRAZY: AN ETHNOGRAPHY OF PSYCHIATRIC CLIENTS IN AN AMERICAN COMMUNITY (1981)). Nonmuscular physical side effects that regularly result from antipsychotic drugs include drowsiness, dizziness, blurred vision, dry mouth, "torn-up" stomach,

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[3] See, *e.g.*, Ayd, *A Survey of Drug-Induced Extrapyramidal Reactions*, 175 J.A.M.A. 1054 (1961); Crane, *Clinical Psychopharmacology in Its 20th Year*, 181 Sci. 124 (1973); Kennedy, Hershon & McGuire, *Extrapyramidal Disorders After Prolonged Phenothiazine Therapy*, 118 Brit. J. Psych. 509 (1971).

low blood pressure, palpitations, skin rashes, and constipation.[4] Less frequent physical side effects such as skin discoloration, ocular and cardiovascular changes, loss of the body's ability to adjust to temperature changes, and sudden death have also been documented.[5] Antipsychotic drugs have been found to cause a loss of white blood cells, thereby exposing the body to infection—a condition known as agranulocytosis,[6] which is fatal in 30% of the cases in which it occurs.[7]

Although the side effects described above are both frightening and serious, the most debilitating effect linked to antipsychotic drugs is a condition known as tardive dyskinesia. As the district court found, tardive dyskinesia is a neurological syndrome manifested by continuous involuntary movements of the face, lips, tongue, fingers, hands, legs and pelvic areas, such as chewing and lip-smacking motions, drooling and facial contortions. 478 F. Supp. at 1360, Pet. App. at 69a-70a. In its progressive stages, tardive dyskinesia interferes with all motor activity, making speech incomprehensible,

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[4] *E.g., id.*; MODERN SYNOPSIS OF COMPREHENSIVE TEXTBOOK OF PSYCHIATRY/II 943, 956-61 (A. Freedman, H. Kaplan & B. Sadock eds. 1976).

[5] *E.g.*, Ayd, *Cardiovascular Effects of Phenothiazines*, 5 Int'l Drug Therapy Newsletter 1 (1970); Moore & Book, *Sudden Death in Phenothiazine Therapy*, 44 Psych. Q. 389 (1970); Shader, Appleton & DiMascio, *Ophthalmological (Pigmentary) Changes*, in PSYCHOTROPIC DRUG SIDE EFFECTS 107 (R. Shader & A. DiMascio eds. 1970); Yang & Guillan, *Sudden Death Syndrome*, J. Kan. Med. Soc. 547 (1979).

[6] Ananth & Beszterczey, *Treatment of Psychosis Subsequent to Phenothiazine-induced Agranulocytosis*, 14 Compr. Psych. 319, 322 (1973); see Baldessarini & Lipinski, *Risks vs. Benefits of Antipsychotic Drugs*, 289 New Eng. J. Med. 427, 428 (1973).

[7] Dubose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?*, 60 Minn. L. Rev. 1149, 1205-06 (1976).

breathing and swallowing extremely difficult, and sometimes causing death. *Id.*[8] Insidiously, the antipsychotic drugs which cause this condition mask its early stages; once discovered, it is generally considered irreversible, although cases of spontaneous remission have been reported.[9]

There is little doubt that prolonged administration of antipsychotic drugs plays a major role in the development and incidence of tardive dyskinesia.[10] The condition usually begins after at least three months of exposure to antipsychotic drugs. J.A. 84 ¶ 27. As noted by the district court, studies have placed the incidence rates of tardive dyskinesia in mental hospitals at between 30% and 56%, and for outpatients at 41%. 478 F. Supp. at 1360 & n.8, Pet. App. at 70a & n.8.[11] A special task force of *amicus* American Psychiatric Association has recognized that tardive dyskinesia is a "general public health problem of major proportions, which may interfere with the ultimate rehabilitation of the patient in the community." *APA Task Force Report, supra*, at 2.

B. Cognitive and Emotional Side Effects

Antipsychotic drugs also produce negative cognitive and emotional side effects. The *amicus* brief of the

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[8] See, *e.g.*, Klawans *et al.*, *Neuroleptic-Induced Tardive Dyskinesias in Nonpsychotic Patients*, 30 Arch. Neurology 338 (1974); Sovner *et al.*, *Tardive Dyskinesia and Informed Consent*, 19 Psychosomatics 172 (1978).

[9] *E.g.*, PHYSICIANS DESK REFERENCE 1633 (33d ed. 1979); Baldessarini & Lipinski, *supra* note 6, at 428; Sovner *et al.*, *supra* note 8, at 173.

[10] See, *e.g.*, Baldessarini & Lipinski, *supra* note 6, at 428; Crane, *The Prevention of Tardive Dyskinesia*, 134 Am. J. Psych. 756 (1977); Klawans, *The Pharmacology of Tardive Dyskinesia*, 130 Am. J. Psych. 82 (1973).

[11] See, *e.g.*, *APA Task Force Report, supra*, at 44; Sovner *et al.*, *supra* note 8, at 173; Tepper & Haas, *Prevalence of Tardive Dyskinesia*, 24 J. Clin. Psych. 508 (1979).

American Psychiatric Association suggests that antipsychotic drugs only assist and never impair the thinking process (at 16). But in fact these drugs often adversely affect the individual's ability to produce thoughts, destroying concentration and making reading and talking impossible. Those detrimental effects may be worse than the cognitive impairments, if any, attributable to mental illness. See, *e.g.*, Goldstone *et al.*, *Effects of Trifluoperazine, Chlorpromazine, and Haloperidol Upon Temporal Information Processing by Schizophrenic Patients*, 65 Psychopharmacology 119, 123 (1979).[12]

On an emotional level, the symptoms of tardive dyskinesia are grotesque and socially objectionable, causing considerable shame and embarrassment to those affected. At best, they have a very detrimental effect on self-image and esteem;[13] at worst, "suicide may ensue." Sovner *et al.*, *Tardive Dyskinesia and Informed Consent*, 19 Psychosomatics 172, 173 (1978). Not surprisingly, then, the district court found that the symptoms of tardive dyskinesia are not only physically disabling, but also psychologically destructive. 478 F. Supp. at 1360, Pet. App. at 70a.

People who are given antipsychotic drugs and have the good fortune to avoid tardive dyskinesia are still likely to become anxious, agitated, and restless. *E.g.*, S. Estroff, *supra*, at 109-12. They may also become depressed, with diminished spontaneity and feelings of extreme weakness and muscle fatigue. Persons experiencing these symptoms have described their lives as "empty," "aimless," or "unenthusiastic." Brooks, *supra*, at 184. They appear "blunted and sad, detached and disinterested and feel

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[12] *See also* K. Hammond & C. Joyce, PSYCHOACTIVE DRUGS AND SOCIAL JUDGMENT: THEORY AND RESEARCH 109-20 (1975).

[13] See Crane, *Two Decades of Psychopharmacology and Community Mental Health: Old and New Problems of the Schizophrenic Patient*, in 36 TRANSACTIONS OF THE N.Y. ACAD. OF SCIENCES, ser. II at 644, 646 (1974).

morose, hopeless and gloomy." Estroff, *supra*, at 109-12. Unable to control their drug-induced emotions, such persons may withdraw in despair. This depression and anxiety, "in experience for the [individual] and in appearance for others, serve to perpetuate separateness and lack of involvement." *Id.*

C. Alternative Forms of Treatment

While the adverse side effects of antipsychotic drugs are well documented, evidence supporting the asserted positive effects of the drugs is far from conclusive. See *APA Task Force Report, supra. See generally* Eisenberg, *Psychiatric Intervention*, 229 Scientific Am. 116 (1973). Recent studies have questioned the necessity and efficacy of antipsychotic drugs that are freely prescribed for various mental disorders. See Gunderson, *Drugs and Psychosocial Treatment of Schizophrenia Revisited*, 38 J. Cont. Educ. Psych. 25 (1977); Karon & VandenBos, *The Consequences of Psychotherapy for Schizophrenic Patients*, 9 Psychotherapy: Theory, Research & Prac. 111 (1972); Van Putten, *Subjective Response as a Predictor of Outcome in Pharmacotherapy*, 35 Arch. Gen. Psych. 477 (1978) ("a sizeable proportion of schizophrenics improve when receiving placebo alone").

Treatment methods less intrusive and dangerous than antipsychotic medication are both available and effective. When antipsychotic drugs first came into widespread use in the 1950s, they were labeled as a treatment which made all other forms of therapy obsolete. See R. Baldessarini, CHEMOTHERAPY IN PSYCHIATRY 2 (1977). This belief has long since been discredited. Although antipsychotic drugs are undoubtedly beneficial for many patients, they are by no means the "antibiotics" of the mental health field as suggested by *amicus* American Psychiatric Association (at 14). Other therapies have been shown to bear equal or greater promise of long-term improvement. See B. Karon & G. VandenBos, PSYCHOTHERAPY OF SCHIZOPHRENIA: THE TREATMENT OF CHOICE (1981); G. Paul

& R. Lentz, PSYCHOSOCIAL TREATMENT OF CHRONIC MENTAL PATIENTS (1977) (social learning treatment more effective in the long run than medication); Gunderson, *supra* (antipsychotic drugs merely one of several available methods for treating schizophrenia). As one group of scientists has observed: "[t]he long-term outcome for schizophrenia does not appear to have improved since the advent of phenothiazines . . . and [experts] feel that any improvement in the well-being of these patients is due equally to modern psychosocial measures." Hershon, Kennedy & McGuire, *Persistence of Extrapyramidal Disorders and Psychiatric Relapse after Withdrawal of Long-Term Phenothiazine Therapy*, 120 Brit. J. Psych. 41 (1972).

A significant study of hospitalized, acutely ill patients compared patients receiving psychotherapy to similar patients receiving antipsychotic drugs. A surprisingly small number of psychotherapy sessions (less than four a month) were shown to produce dramatic results. Patients treated with psychotherapy as compared to those receiving antipsychotic drugs "showed less thought disorder, . . . spent much less time in the hospital, and were able to live their lives more like human beings in a wide variety of ways." B. Karon & G. VandenBos, *supra*, at 371. *See also* G. Paul & R. Lentz, *supra*.

II. ABSENT AN EMERGENCY, ALL PERSONS WHO ARE COMPETENT HAVE A CONSTITUTIONALLY PROTECTED RIGHT TO BE FREE TO DECIDE WHETHER TO SUBMIT TO THE ADMINISTRATION OF ANTIPSYCHOTIC DRUGS BY THE STATE.

A. When Important State Interests Conflict with Constitutionally Protected Individual Interests, Careful Balancing Is Required.

This Court has not previously addressed the extent to which persons committed to mental institutions suffer a consequent diminution of their various liberty interests.

In the case of prisoners, a different confined population, this Court repeatedly has held that "convicted prisoners do not forfeit all constitutional protections by reason of their conviction and confinement in prison." *Bell* v. *Wolfish*, 441 U.S. 520, 545 (1979); *accord*, *Wolff* v. *McDonnell*, 418 U.S. 539, 555-56 (1974) ("There is no iron curtain drawn between the Constitution and the prisons of this country.").[14]

To determine the extent to which the constitutionally protected interests of prisoners remain intact in various penal situations, the Court first has identified the prisoners' liberty interests and then has balanced those interests against the interests of the state in operating prisons. "[T]here must be a mutual accommodation between institutional needs and objectives and the provisions of the Constitution that are of general application." *Wolff* v. *McDonnell*, *supra*, 418 U.S. at 556. *See also Roe* v. *Wade*, 410 U.S. 113 (1973). The stronger the individual interest potentially affected, the greater has been the burden imposed upon the state to justify any intrusion on that interest.[15]

If constitutionally protected interests of individuals exist even within the walls of a prison, they must also

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[14] The Court repeatedly has distinguished between "conditions of confinement that are not alleged to infringe any other, more specific guarantee of the Constitution" and violations of "fundamental liberty interests." *E.g.*, *Bell* v. *Wolfish*, *supra*, 441 U.S. at 533, 534. Where, as in this case, fundamental rights rather than mere conditions of confinement are at stake, the Court has applied a careful balancing analysis. See, *e.g.*, *Bell* v. *Wolfish*, *supra*; *Cruz* v. *Beto*, 405 U.S. 319 (1972) (per curiam).

[15] While courts may pay deference to the expertise of the institutional administrators in performing this balance, "a policy of judicial restraint cannot encompass any failure to take cognizance of valid constitutional claims whether arising in a federal or state institution." *Procunier* v. *Martinez*, 416 U.S. 396, 405 (1974).

continue to have vitality within a state mental institution. See *Addington* v. *Texas*, 441 U.S. 418 (1978); *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975). Although analogy to the method of analysis used in the prison cases is appropriate, it goes without saying that a mental institution is not a prison.[16] When evaluating constitutional rights of involuntarily committed persons, the balancing test applied in such cases as *Bell* v. *Wolfish*, *Wolff* v. *McDonnell*, and *Roe* v. *Wade* requires the Court to take into account the particular individual and public interests involved in the unique environment of a state mental institution.

Amici do not dispute that properly applied civil commitment procedures authorize the state to involuntarily confine certain individuals, and that the state may validly limit the constitutional interests of such persons which necessarily are infringed as a direct consequence of confinement itself. In the instant case, however, committed individuals assert important constitutional liberty interests relating to bodily integrity, free thought, and self-determination which are not necessarily diminished by state-imposed involuntary commitment. These individual liberty interests, along with the countervailing state interests implicated by civil commitment, are discussed below.

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[16] Prisoners' interests are necessarily evaluated within the framework of their past criminal activities and the specific objectives of the criminal justice system. *Jones* v. *North Carolina Prisoners' Union*, 433 U.S. 119, 129 (1977). By contrast, civilly committed persons generally have committed no crime, but have been deprived of their liberty because of a condition beyond their control. See *Addington* v. *Texas*, *supra*, 441 U.S. at 428; *O'Connor* v. *Donaldson*, *supra*. As the district court aptly noted, civilly committed mental patients "are victims of fate who have been shortchanged by life." 478 F. Supp. at 1369, Pet. App. at 97a-98a.

B. Persons Who Are Able to Make Decisions for Themselves Have Fundamental Constitutional Interests in Being Free to Decide Whether to Submit to the Administration of Antipsychotic Drugs.

Administering antipsychotic drugs against an individual's will infringes a variety of liberty interests protected by the Constitution. In identifying the individual's interests to be balanced, this Court must look to "[t]he full scope of the liberty guaranteed by the Due Process Clause [which] cannot be . . . limited by the precise terms of the specific guarantees elsewhere provided in the Constitution." *Moore* v. *City of East Cleveland*, 431 U.S. 494, 502 (1977) (quoting *Poe* v. *Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting)); see L. Tribe, AMERICAN CONSTITUTIONAL LAW § 11-3 at 569 (1978). As the court of appeals held, although "[t]he precise textual source in the Constitution of the protection of [the individual's interests] is unclear, . . . a source in the Due Process Clause of the Fourteenth Amendment for the protection of this interest exists, most likely as part of the penumbral right to privacy, bodily integrity, or personal security." 634 F.2d at 653, Pet. App. at 4a-5a. In forcibly administering antipsychotic drugs, the state intrudes upon three separate but related aspects of an individual's liberty interest: (1) the interest in bodily integrity and personal security; (2) the interest in being able to think and communicate freely; and (3) the interest in being free to make decisions about one's own body and mind.

This Court has recognized that "[a]mong the historic liberties [protected by the due process clause] was a right to be free from . . . unjustified intrusions on personal security." *Ingraham* v. *Wright*, 430 U.S. 651, 672-73 (1977); see *Breithaupt* v. *Abram*, 352 U.S. 432, 439 (1957). As the Court has stated, "[n]o right is held more sacred, or is more carefully guarded . . .

than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pacific Railway* v. *Botsford*, 141 U.S. 250, 251 (1891); see L. Tribe, AMERICAN CONSTITUTIONAL LAW § 15-9 at 913 (1978). A respect for each individual's bodily integrity underlies the specific guarantees of the fourth amendment, *e.g.*, *Sibron* v. *New York*, 392 U.S. 40, 65-66 (1968); *Schmerber* v. *California*, 384 U.S. 757, 772 (1966); the eighth amendment, *e.g.*, *United States* v. *Georvassilis*, 498 F.2d 883 (6th Cir. 1974); and the due process clauses of the fifth and fourteenth amendments, *e.g.*, *Ingraham* v. *Wright*, *supra*, 430 U.S. at 672-75; *Rochin* v. *California*, 342 U.S. 165, 172, 174 (1952).

The Constitution protects not only one's interest in bodily integrity and personal security, but also the inviolability of one's mind. Every person has a right to think his own thoughts, free of state intervention or manipulation. Government control of a competent individual's mind through the use of antipsychotic drugs would be wholly inconsistent not only with the philosophy of the first amendment, but with virtually any concept of liberty. See, *e.g.*, *Stanley* v. *Georgia*, 394 U.S. 557, 565-66 (1969). The Court has recognized that "in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State." *Abood* v. *Detroit Board of Education*, 431 U.S. 209, 235 (1977). "Indeed, the State's power to control the minds of its subjects is the hallmark of those 'totalitarian ideologies we profess to hate . . . .'" *Davis* v. *Hubbard*, 506 F. Supp. 915, 933 (N.D. Ohio 1980) (quoting *Sobell* v. *Reed*, 327 F. Supp. 1294, 1305 (S.D.N.Y. 1971)). *See also Mackey* v. *Procunier*, 477 F.2d 877, 878 (9th Cir. 1973); Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 So. Cal. L. Rev. 237, 253-76 (1974).

Closely related to the individual's interests in bodily integrity and the freedom to think and communicate freely is the interest in being free to make important decisions about one's own body and mind. This interest in self-determination is grounded in respect for individual choices, "which is the lifeblood of the law." *Faretta* v. *California*, 422 U.S. 806, 834 (1975) (quoting *Illinois* v. *Allen*, 397 U.S. 337, 350-51 (1970)). This Court consistently has held that individuals have a constitutionally protected interest in making particularly personal or intimate decisions. See, *e.g.*, *Roe* v. *Wade*, *supra* (pregnancy); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972) (contraception); *Loving* v. *Virginia*, 388 U.S. 1 (1967) (marriage); *Prince* v. *Massachusetts*, 321 U.S. 158 (1944) (family relationships); *Skinner* v. *Oklahoma*, 316 U.S. 535 (1942) (procreation); *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925), and *Meyer* v. *Nebraska*, 262 U.S. 390 (1923) (child rearing). *See also Whalen* v. *Roe*, 429 U.S. 589, 599-600 (1977).

C. Except in Emergencies or in Cases of Incompetency, the State Has No Interests That Are Sufficient to Override an Individual's Constitutionally Protected Interests in Being Free to Decide Whether to Submit to the Administration of Antipsychotic Drugs.

As noted above, the individual's fundamental liberty interests in being free to decide whether to accept antipsychotic drugs must be balanced against countervailing state interests. The state interests asserted to justify forcing an individual to take these drugs are: (1) the interest in the treatment and care of incompetents, under the *parens patriae* power; (2) the interest in protecting society from imminent danger, under the police power; (3) the interest in protecting the general health of society, also under the police power; and (4) the interest in the secure and efficient administration of mental institutions. As will be demonstrated, none of these

asserted interests is sufficient to outweigh the constitutionally protected interests of a committed person who is able to decide for himself whether to take antipsychotic drugs.

1. ***The State's* Parens Patriae *Interest Applies Only to Civilly Committed Persons Who Have Been Adjudicated Incompetent.***

   a. ***The* parens patriae *power applies only to persons who are incapable of making treatment decisions.***

Amici do not challenge the state's *parens patriae* interest in making treatment decisions for those who are *not* able to make decisions or to act for themselves.[17] But as will be shown below, the state has no valid *parens patriae* interest with respect to persons who *are* able to make decisions and act for themselves.

Under English common law, the sovereign, as father of the country, was responsible for "all persons . . . incompetent to take care of themselves." *In re Barker*, 2 Johns. Ch. 232, 236 (N.Y. 1918) (citing *Beverly's Case*, 4 Co. Rep. 123b, 127a-28a, 76 Eng. Rep. 1118, 1125-26 (K.F. 1603)); see *O'Connor* v. *Donaldson*, *supra*, 441 U.S. at 583 (Burger, C.J., concurring); *Hawaii* v. *Standard Oil Co.*, 405 U.S. 251, 257 (1972); 1 W. Blackstone, *Commentaries* *304; 3 *id.* *47; *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L.

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[17] The court of appeals remanded to the district court the task of developing "substitute consent" procedures to protect incompetent patients. Because the district court has not yet had an opportunity to act on this issue, and because the Massachusetts Supreme Judicial Court's recent decision in *In re Guardianship of Richard Roe, III*, No. SJC-2257 (Mass. Sup. Jud. Ct. April 23, 1981), may well resolve the issue as a matter of state law, this Court should not address at this time what procedures may be constitutionally required to protect incompetent patients.

Rev. 1190, 1207-08 (1974) [hereinafter cited as *Developments*]. Historically premised upon the incapacity of minors, idiots, and lunatics to understand and to care for themselves, the *parens patriae* power purposefully was limited to the protection of those unable to make their own decisions concerning personal care and welfare. See, *e.g.*, *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 583 (Burger, C.J., concurring) (*parens patriae* scheme for protection of mentally ill "must rest upon a legislative determination . . . that [such persons] are unable to act for themselves."). The exercise of this state interest was thus restricted in order to protect competent citizens' liberty interests.

The policy rationale for this strict limitation of the *parens patriae* power was to restrain the state's paternalistic tendencies and ensure the individual's "independence in making certain kinds of important decisions." *Whalen* v. *Roe*, *supra*, 429 U.S. at 599-600. The state's imposition of its treatment decisions upon persons "with the mental capacity to determine the desirability . . . [of antipsychotics] in accordance with their personal values would interfere with individual autonomy and physical liberty without any assurance that the state, as a substitute decisionmaker, would better ascertain the best interest of the individual." *Developments*, *supra*, at 1213-14; see 634 F.2d at 657, Pet. App. at 17a-18a. Moreover, the individual's capacity to decide cannot be conditioned on his arriving at the "right" decision, as defined by the state. "A judgment of the need for a substitute decisionmaker based on the apparent wisdom of the individual's decision [rather than his decisionmaking capacity] poses a risk that the *parens patriae* power will become a means of enforcing social conformity." *Developments*, *supra*, at 1217 n.87. The court of appeals in the present case correctly recognized these principles in holding that "the *sine qua non* for the state's use of its *parens patriae* power as justification for the forceful

administration of mind-affecting drugs is a determination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether he should take the drugs." 634 F.2d at 657, Pet. App. at 17a-18a; *accord, Rennie* v. *Klein*, Nos. 79-2576 & 79-2577, slip op. at 43-44 (3d Cir. July 9, 1981) (en banc) (Garth, J., concurring); *Winters* v. *Miller*, 446 F.2d 65, 70-71 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971).

b. *Under Massachusetts law, incapacity to make decisions is established at a competency hearing, and even civilly committed persons are presumed to be able to make decisions for themselves unless they have been adjudicated incompetent.*

Historically, persons who were involuntarily committed to mental institutions were conclusively presumed to be incompetent for all purposes.[18] This presumption has come under vigorous attack in the past two decades from both the legal and mental health communities. As Professor Alan Stone, recent past president of *amicus* American Psychiatric Association, has written, many committed persons "may be fully capable of weighing the risks and benefits of a proposed treatment." Stone, *Informed Consent: Special Problems for Psychiatry*, 30 Hosp. & Comm. Psych. 321, 326 (1979). And the presumption of incompetency has a "destructive psychological impact . . . [which] complicate[s] the therapeutic decision . . . and interfere[s] with efforts at rehabilitation." Stone, *The*

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[18] The opinion of some courts was that the decision to commit involved a determination that the mentally ill individual "has ceased to be a man," *Howard* v. *Howard*, 87 Ky. 616, 623, 9 S.W. 411, 413 (1888), or "has no will of his own," *In re Oakes*, 8 Law Rep. 122, 125 (Mass. 1845).

Right to Refuse Treatment, 38 Arch. Gen. Psych. 358, 359 (1981).[19]

Consistent with the current statutory schemes of the overwhelming majority of states, Massachusetts presumes the competency of civilly committed persons.[20] Under

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[19] As early as 1962, *amicus* American Psychiatric Association acknowledged that hospitalization is not necessarily related to competence to make decisions:

> "It must be clearly understood that the establishment of a mental illness does not, *ipso facto*, warrant a finding of incompetency . . . . From a medical point of view, there is not, necessarily, any connection between the two . . . . [A]ll laws governing mental illness should recognize that *many hospital patients are perfectly capable of handling their own affairs* and that any automatic tie-up of incompetency and commitment is harmful."

Joint Info. Serv. of Am. Psych. Ass'n & Nat'l Ass'n for Mental Health, *Psychiatric Points of View Regarding Laws and Procedures Governing Medical Treatment of the Mentally Ill* (Special Info. Bull. No. 1, Sept. 1962) (emphasis added).

It is now generally accepted that many forms of mental illness have a specific impact on the individual, leaving decisionmaking capacity and reasoning ability largely unimpaired. M. Lorr, C. Klett & D. McNair, SYNDROMES OF PSYCHOSIS 8, 178-80 (1963) (cognitive disorientation is absent in hostile paranoid schizophrenia); see J. Neale & T. Oltmans, SCHIZOPHRENIA 24 (1980); Helmchen, *Schizophrenia: Diagnostic Concepts in the ICD-8*, in STUDIES OF SCHIZOPHRENIA (M. Lader ed. 1975) (disturbances of comprehension, memory and awareness absent among as many as two-thirds of schizophrenics); *Developments*, *supra*, at 1214. In fact, patients often have good reasons for refusing drugs; for example, in one study, a high percentage of those who objected to drugs had experienced serious side effects from previous drug treatment. Van Putten, *Why Do Schizophrenic Patients Refuse to Take Their Drugs?*, 31 Arch. Gen. Psych. 67, 68 (1974).

[20] Mass. Gen. Laws Ann. ch. 123, § 25 (West Supp. 1981), Pet. App. at 193a-194a; *e.g.*, Cal. Welf. & Inst. Code § 5331 (Supp. 1980); Ill. Ann. Stat. ch. 91-1/2, § 2-101 (Smith-Hurd Supp. 1980); N.J. Stat. Ann. § 30:4-24.2(c) (West 1981); N.Y. Mental Hyg. Law § 29.03 (McKinney 1978); Ohio Rev. Code Ann. § 5122.301 (Page 1981); see Stone, *The Right To Refuse Treatment*, 38 Arch. Gen. Psych. 358, 359 (1981).

Massachusetts law, the criteria for civil commitment are that the individual is mentally ill and that failure to impose hospitalization would create a "likelihood of serious harm." Mass. Gen. Laws Ann. ch. 123, §§ 7-8 (West Supp. 1981), Pet. App. at 188a-191a.[21] These statutory criteria do not signify that a decision to commit is equivalent to a finding that the individual is incapable of deciding whether to accept an intrusive mode of treatment. Both the district court and court of appeals correctly found that, until adjudicated incompetent, an individual is presumed competent, even if civilly committed. 478 F. Supp. at 1361, Pet. App. at 75a; 634 F.2d at 658-59, Pet. App. at 22a-23a.

Having severed the determination of incapacity from the civil commitment proceeding, the Massachusetts legislature chose to require a separate proceeding in probate court for the incapacity determination. See Mass. Gen. Laws Ann. ch. 201, §§ 6, 6A & 14 (West Supp. 1981).[22] At such a competency hearing, an individual can be adjudicated incapable of making informed decisions, and thereby have a guardian appointed as a substitute decisionmaker. *Fazio* v. *Fazio*, 375 Mass. 394, 403, 378 N.E.2d 951, 957 (1978). But, as noted above, until an

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[21] "Mental illness" is defined by Massachusetts Department of Mental Health Regulation § 200.01, J.A. 20-21. The statutory definition of "likelihood of serious harm" is contained in Mass. Gen. Laws Ann. ch. 123, § 1 (West Supp. 1981), Pet. App. at 183a-184a.

[22] Of course, a state could statutorily require a determination of incompetency as a necessary criterion for involuntary civil commitment, and thereby assert its *parens patriae* power over all subsequently committed individuals. See, *e.g.*, S.C. Code § 44-17-580 (Supp. 1980); Tex. Rev. Civ. Stat. Ann. art. 5547-41 (Vernon Supp. 1980-81); Utah Code Ann. § 64-7-36 (10)(c) (Supp. 1979). Or the state could merge a competency determination with the commitment proceedings in order to clarify such matters one way or the other prior to the individual's commitment. See, *e.g.*, Ind. Code Ann. § 16-14-9.1-11 (Burns Supp. 1980). Massachusetts has chosen neither of these statutory schemes.

adjudication of incompetency, the individual is statutorily presumed to be competent, even after involuntary commitment: "No person shall be deemed to be incompetent to manage his affairs . . . *solely by reasons of his* admission or *commitment* in any capacity to the treatment or care of the department or to any public or private facility, nor shall departmental regulations restrict such rights." Mass. Gen. Laws Ann. ch. 123, § 25 (West Supp. 1981), Pet. App. at 193a-194a (emphasis added). The relevant Massachusetts Department of Mental Health (DMH) regulation goes even further, stating that "[n]o person shall be deprived of the right to manage his affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make a will, to marry, to hold or convey property, or to vote . . . *solely by reason of his . . . commitment . . . except where there has been an adjudication that such person is incompetent . . . .*" DMH Reg. § 221.02, J.A. 23 (emphasis added). And the Massachusetts Supreme Judicial Court recently has held that "[a] person is presumed to be competent unless shown by the evidence not to be competent," and that "[t]his presumption continues *even while the person is committed to a public or private institution.*" *In re Guardianship of Richard Roe, III*, No. SJC-2257, slip op. at 36 & n.15 (Mass. Sup. Jud. Ct. April 23, 1981) (emphasis added); *cf. Boyd* v. *Board of Registrars of Voters of Belchertown*, 368 Mass. 631, 635-36, 334 N.E.2d 629, 632 (1975) ("profound" distinction between commitment and determination of incompetency).[23]

Thus, under Massachusetts law, a committed individual is presumed capable of making his own decisions about

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[23] These holdings are directly supported by courts in other jurisdictions with similar statutory schemes. *E.g., Rennie* v. *Klein*, Nos. 79-2576 & 79-2577, slip op. at 19 & n.12 (3d Cir. July 9, 1981) (en banc); *Winters* v. *Miller*, 446 F.2d 65, 68-71 (2d Cir.), *cert. denied*, 404 U.S. 985 (1972); *In re Boyd*, 403 A.2d 744, 747 n.5 (D.C. 1979); *In re K.K.B.*, 609 P.2d 747, 749 (Okla. 1980).

antipsychotic drug treatment unless he has been adjudicated incompetent.[24] As the district court found, "although committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks, and discomfort that may reasonably be expected from receiving . . . [antipsychotic] medication." 478 F. Supp. at 1361, Pet. App. at 74a. In *amici's* view, Massachusetts law is well advised because a competent patient might prefer to avoid the intrusive side effects that accompany the administration of these drugs, even at the risk of continuing mental disorder and possible prolonged commitment. Such a preference is all the more understandable given "the lack of certainty and the fallibility of psychiatric diagnosis," *Addington* v. *Texas*, *supra*, 441 U.S. at 429, and "the tentativeness of professional judgment" in the field of psychiatric treatment. *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 584 (Burger, C.J., concurring.)[25]

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[24] The concerns about improper intrusion into professional decisionmaking by the courts which are expressed in the briefs of petitioners and *amicus* American Psychiatric Association are based on a misunderstanding of the nature of the hearing required to determine competency. An adjudication of incompetency does not require the courts to render substantive psychiatric judgments with respect to treatment. The patient's ability to make a decision is the *only* issue decided at a competency hearing, and such determinations traditionally have been handled by the courts.

[25] The state's position that it can impose treatment over a patient's objection cannot be squared with its practice of giving each new patient at Boston State Hospital a pamphlet stating that he is entitled to choose from alternative treatments, and "to refuse treatment at any point." J.A. 36; Pet. Br. at 71 n.24. That Massachusetts provides by statute and regulation that committed individuals have the right to refuse electroconvulsive treatment or lobotomy unless and until adjudicated incompetent is further evidence that the state recognizes the ability of such persons to make treatment decisions. Mass. Gen. Laws Ann. ch. 123, § 23 (West Supp. 1981), Pet. App. 191a-193a; DMH Reg. § 220.02, Pet. App. 194a-195a. Petitioners do not explain why a person competent to

2. *The State's Interest in Taking Emergency Action to Ensure Security in the Institution Is Adequately Protected by the Ruling of the Court of Appeals.*

Amici agree that the state has legitimate institutional interests in the internal security of its mental hospitals. An emergency situation which creates a danger to the institution's staff, to other residents, or to a particular patient himself is adequately addressed under the standard developed by the court of appeals. Under that standard, forcible medication is allowed, even for a competent patient, where a staff physician in his professional judgment makes an individual determination that "the need to prevent violence in a particular situation outweighs the possibility of harm to the medicated individual." 634 F.2d at 656, Pet. App. at 14a.[38]

Respondents have not challenged that portion of the court of appeals' ruling. The principal issue in this case is whether the state has other sufficient interests to justify forcibly medicating a competent patient who poses no threat to institutional safety.

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make treatment decisions concerning electroshock therapy or lobotomy is not also competent to make such decisions concerning antipsychotic drugs. To the extent that petitioners suggest that state law contemplates that competent patients may be forcibly treated with antipsychotic drugs (Pet. Br. at 31-32 & n.9), both courts below ruled to the contrary. 634 F.2d at 657-61, Pet. App. at 18a-23a; 478 F. Supp. at 1361-64, Pet. App. at 73a-79a. Doubts about such rulings would require certification of state law questions to the Massachusetts Supreme Judicial Court.

[38] *But see* Brief for the American Psychiatric Association as *Amicus Curiae* at 20 n.18, where it is suggested that the use of antipsychotic medication for restraint purposes is never clinically appropriate, and is uniformly condemned in psychiatric literature.

3. *The State's Police Power Interest in Improving the Health of Individuals for the Benefit of Society Does Not Outweigh a Competent Individual's Constitutionally Protected Interests.*

As *amici* have demonstrated, under Massachusetts law, the state has no *parens patriae* interest in making treatment decisions for competent persons, even if those patients are committed to a state mental institution. Accordingly, the state's asserted interest in providing treatment to competent residents of its institutions must be justified, if at all, as an interest in improving the health of individuals for the general welfare and protection of society. Such an interest, however, is insufficient to override the constitutionally protected interests of the competent individual.

The courts have strictly limited the power of the state to act to further general societal interests at the expense of the individual's constitutional liberty interests. *E.g.*, L. Tribe, AMERICAN CONSTITUTIONAL LAW § 15-4 at 896 (1978). In balancing the interests at stake, courts have weighed factors such as the relative seriousness of the intrusion, the degree of societal harm likely without state intervention, and the level of certainty that state intervention will prevent such harm. For example, in *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905), this Court held that the state's interest in compulsory vaccination outweighed the individual's right to bodily integrity. In that case, the need to prevent epidemics was a compelling societal interest, the intrusion consisted of a single injection without side effects, and the vaccination was necessary and almost certain to prevent epidemics. Similarly, in *Roe* v. *Wade*, *supra*, the Court balanced a mother's fundamental right to decide whether to terminate her pregnancy and the state's interest in preserving the life of the unborn fetus. As the certainty of the fetus's survival increased, the state's interest in protecting the life of the fetus also increased.

The Court held that after the fetus became viable, the state could severely infringe the mother's right to privacy by restricting or even prohibiting all abortions. Until the point of viability, however, the state could only intrude to regulate the abortion procedure for the protection of maternal health.[27]

In contrast with forced vaccination and abortion, the state's interest in imposing antipsychotic drugs upon a competent individual is far less weighty. First, the state's interests in treatment—in maintaining healthy citizens, in increasing the productivity of its citizens, in protecting the person's dependents, in providing proper medical care, and in shortening the period of institutional care—are not as compelling as the need to prevent life-threatening epidemics or to preserve the life of a viable fetus.[28] Second, unlike vaccination, antipsychotic drugs dramatically affect the body and mind of the individual

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[27] *See generally State* v. *Also*, 11 Ariz. App. 227, 230, 463 P.2d 122, 125 (1969), and *Everhardt* v. *City of New Orleans*, 253 La. 285, 217 So. 2d 400 (1968), *appeal dismissed and cert. denied*, 395 U.S. 212 (1969) (motorcycle helmet law permissible because only a minor infringement); *Schuringa* v. *City of Chicago*, 30 Ill. 2d 504, 518, 198 N.E.2d 326, 333-34 (1964), *cert. denied*, 379 U.S. 964 (1965) (fluoridation of water supply permissible because only a minor infringement).

[28] Even when a strong state interest is at stake, the state may not conduct bodily intrusions which are "brutal," "offensive" or "shock the conscience." *Rochin* v. *California*, *supra*, 342 U.S. at 172. Moreover, there is no valid reason to distinguish competent residents of an institution from other competent individuals allowed by a state to make the decision whether to submit to intrusive medical treatment. The state interests asserted here apply with equal or greater force to citizens hospitalized for a physical illness. Society does not allow the state to impose surgery, even obviously beneficial surgery, on a nonconsenting, competent adult. In *amici*'s view, it would be equally improper to allow the state to force antipsychotic drugs on an objecting, competent mental patient.

and have dangerous and often permanent side effects. Finally, it is far from certain whether antipsychotic drugs have long-term benefits.

Under the balancing test, if the form of treatment at issue were less intrusive, less dangerous, and more certain of success than antipsychotic drugs, the state's interest in imposing such treatment on institutionalized patients for the public health might arguably outweigh the individual's interests. Or, if no equally effective and more acceptable alternative forms of treatment were available to address the state's goal, the state's interests in imposing antipsychotic drugs on institutionalized patients for the general welfare might arguably outweigh the individual's interests. See, *e.g.*, *Pell* v. *Procunier*, 417 U.S. 817, 824-27 (1974). However, because of the extent of the intrusion involved here, the possibility that harmful side effects may last months or years beyond the period of commitment itself, the questionable effectiveness of this form of treatment, the availability of other effective and more acceptable forms of treatment, and the well-documented tendency of state hospitals to misuse and overuse drugs for the convenience of staff and for punishment,[29] the state's interest in the general welfare does not justify imposition of antipsychotic medication over a patient's objections.

4. ***The State's Only Additional Interest Is the Efficient Operation of the Institution, and That Interest Does Not Outweigh a Competent Individual's Constitutionally Protected Interests.***

As a final interest, petitioners assert that substantial disruption of mental-institution operations will necessarily follow if competent patients are allowed to make

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[29] See, *e.g.*, *Davis* v. *Hubbard*, *supra*, 506 F. Supp. at 926 & n.7 (quoting Crane, *Clinical Psychopharmacology, in its 20th Year*, 181 Sci. 124, 125 (1973)).

their own decisions regarding antipsychotic drugs. In support of this claim, the state predicts a return to mental-institution conditions of 30 years ago, when neither modern psychosocial therapies nor medication of any sort were available and when hospitals housed almost three times more patients than during this past decade. O. Ray, DRUGS, SOCIETY AND HUMAN BEHAVIOR 250-51 (1978).[30] Neither the professional literature nor the experience of hospitals that have recognized patients' right to refuse antipsychotic drugs support petitioners' warnings of disaster.

Without exception, institutions that have implemented a right to refuse drugs have found that allowing competent patients to make a choice about drug treatment has not interfered with either the daily operation of the institution or with treatment programs. In New Jersey, for example, a state institution operated for a year under a court order enforcing patients' right to refuse antipsychotic drugs. The psychiatrists and hospital staff experienced little disruption in treating patients. In fact, substantial savings in medication costs were realized,

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[30] Statistical studies make clear that the causes of decreased psychiatric hospital populations and shorter median lengths of stay are attributable to a complex array of factors, not solely to the advent of antipsychotic drugs, as suggested by *amicus* American Psychiatric Association (at 14-15). Some important developments and factors which have been identified as at least equally responsible for these positive results include the increased availability of outpatient facilities, the changing locus of inpatient care away from state and county mental hospitals, and modifications in state legislation regarding commitment and periodic review of patients. See *NIMH Memorandum No. 2: Forty-one Percent Decline in Length of Stay for State and County Hospitals* at 1 (1977); Ozarin, Redick & Taube, *A Quarter Century of Psychiatric Care, 1950-1974: A Statistical Reveiw*, 27 Hosp. & Comm. Psych. 515, 516 (1976); Taube, Regier & Rosenfeld, *Mental Disorders*, in U.S. Dept. of Health, Education & Welfare, HEALTH, UNITED STATES 69, 73, 75 (1978).

fewer side effects occurred, and, most significantly, "[t]reatment itself . . . improved . . . [without] substantial additional burdens . . . placed on treatment personnel." Brooks, *supra*, at 213. Similarly, in Ohio, where the patients' right to refuse treatment was implemented after litigation, the district court found no evidence suggesting that the "recognition of the right has had any adverse effects on the operation of the institution or on its treatment goals." *Davis* v. *Hubbard*, *supra*, 506 F. Supp. at 937 n.31.

In this case, Boston State Hospital operated for a year under a temporary restraining order imposing requirements far more stringent than those adopted by the court of appeals. During that period, the institution treated 1,000 patients without substantial disruption. 478 F. Supp. at 1369, Pet. App. at 98a-99a. Whether any incidents occurred which are attributable to the court's order was a matter of substantial dispute between the parties. The court of appeals, although conceding that the district court "may have overlooked or misconstrued evidence of specific acts of violence occurring as a result of defendants' difficulty in applying the court's standard," 634 F.2d at 655, Pet. App. at 9a, condemned the defendants and *amicus* American Psychiatric Association for exaggerating the difficulties. "[T]hroughout this litigation defendants and their supporting *amici* have erroneously attributed the acts of violence to the strictness of the court's standard." *Id.* Indeed, at least one study relied on by defendants concludes that permitting refusals of medication "did not seriously impair [the patients'] overall treatment and yielded some positive advantages." Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Am. J. Psych. 340, 345 (1980).

CONCLUSION

After balancing the individual's interests against those of the state, the court of appeals concluded that the Constitution protects the right of an individual capable of making his own decision to be "left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs." 634 F.2d at 653, Pet. App. at 4a.

For the reasons set forth above, *amici* urge this Court to affirm the judgment of the court of appeals.

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